The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-809-6539 or visit uhc.com/aca-sample-policy. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes, Prescription drugs - $4,500 Individual / $9,000 Family Deductible does not apply to Tier 1, Tier 2 or Tier 3 drugs. There are no other deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network: $9,450 Individual / $18,900 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See uhc.com/xcodocfindrs2024 or call 1-888-809-6539 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office	Primary care visit to treat an injury or illness	$50 copay /visit, deductible does not apply	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
or clinic	Specialist visit	$150 copay /visit, deductible does not apply	Not Covered	None
	Preventive care/ screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Testing: Free Standing/Office: $40 copay /service, deductible does not apply Hospital: $150 copay /service, deductible does not apply X-Ray/Diagnostics: Free Standing/Office: $100 copay /service, deductible does not apply Hospital: $150 copay /service, deductible does not apply	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Free Standing/Office: $200 copay /service, deductible does not apply Hospital: $800 copay /service, deductible does not apply	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at uhc.com/xcodruglist2024	Tier 1 - Typically Zero Cost-Share Preventive Drugs	No Charge	Not Covered	Provider means pharmacy for purposes of this section. Retail: One month supply up to a 30-day supply or a 90-day supply at 2.5x the 30-day cost share. Mail-Order: Up to a 90-day supply at 2.5x the 30-day cost share. Specialty drugs limited to a 30-day supply at a network pharmacy. Certain drugs may have a preauthorization requirement. If you don't get preauthorization, benefits will not be covered. Certain preventive medications (including certain contraceptives) are covered at No Charge.
	Tier 2 - Typically Preferred Generic	$20 copay /prescription, deductible does not apply	Not Covered	
	Tier 3 - Typically Non-Preferred Generic	$50 copay /prescription, deductible does not apply	Not Covered	
	Tier 4 - Typically Preferred Brand	50% coinsurance	Not Covered	
	Tier 5 - Typically Non-	50% coinsurance	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Preferred Brand			See the website listed for information on drugs covered by your plan. Not all drugs are covered. Insulin products listed on the Prescription Drug List are covered at No Charge at a network pharmacy.
	Tier 6 - Typically Specialty Drugs	50% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$750 copay /service, deductible does not apply	Not Covered	None
	Physician/surgeon fees	Free Standing/Office: $375 copay /service, deductible does not apply Hospital: $1,500 copay /service, deductible does not apply	Not Covered	None
If you need immediate medical attention	Emergency room care	$2,000 copay /visit, deductible does not apply	$2,000 copay /visit, deductible does not apply	None
	Emergency medical transportation	50% coinsurance, deductible does not apply	50% coinsurance, deductible does not apply	None
	Urgent care	$100 copay /visit, deductible does not apply	$100 copay /visit, deductible does not apply	Virtual visits - No Charge by a Designated Virtual Provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	$3,000 copay /day up to 3 days /admission, deductible does not apply	Not Covered	None
	Physician/surgeon fees	50% coinsurance, deductible does not apply	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $150 copay /visit, deductible does not apply Outpatient: $375 copay /visit, deductible does not apply	Not Covered	None
	Inpatient services	$3,000 copay /day up to 3 days /admission, deductible does not apply	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Cost-sharing does not apply for preventive services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	50% coinsurance, deductible does not apply	Not Covered	Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	$3,000 copay /day up to 3 days /admission, deductible does not apply	Not Covered	
If you need help recovering or have other special health needs	Home health care	50% coinsurance, deductible does not apply	Not Covered	Limited to 28 hours /week, not to exceed 60 visits/year.
	Rehabilitation services	$150 copay /visit, deductible does not apply	Not Covered	Limits/year: Physical, Occupational, Speech: 20 visits each; Cardiac, Pulmonary: Unlimited visits each
	Habilitative services	$150 copay /visit, deductible does not apply	Not Covered	Limits/year: Physical, Occupational, Speech: 20 visits each No limits apply for treatment of Autism Spectrum Disorder Services.
	Skilled nursing care	$3,000 copay /day up to 3 days /admission, deductible does not apply	Not Covered	Limited to 100 days/year (combined with inpatient rehabilitation)
	Durable medical equipment	50% coinsurance, deductible does not apply	Not Covered	None
	Hospice services	50% coinsurance, deductible does not apply	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to 1 exam/12 months.
	Children's glasses	50% coinsurance, deductible does not apply	Not Covered	Limited to 1 pair/12 months.
	Children's dental check-up	No Charge	Not Covered	Limited to 2 visits/12 months.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortion - (except in cases of rape, incest, or when the life of the mother is endangered)	• Glasses (Adult)	• Routine eye care (Adult)
• Cosmetic surgery	• Long-term care	• Routine foot care - except as covered for diabetes
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture - 6 visits/year	• Chiropractic (manipulative) care - 20 visits/year	• Infertility treatment - diagnosis and treatment of underlying causes
• Bariatric surgery	• Hearing aids	• Private duty nursing - inpatient only

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Rocky Mountain Health Maintenance Organization Inc. at 1-888-809-6539 or U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202, 1-800-930-3745, DORA_Insurance@state.co.us or doi.colorado.gov or Office of Personnel Management Multi State Plan Program: opm.gov/healthcare-insurance/multi-state-plan-program/external-review/ . Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com/exchange or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or Colorado Division of Insurance at 1-800-930-3745, DORA_Insurance@state.co.us or doi.colorado.gov.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-809-6539
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-809-6539
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-809-6539
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-809-6539

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$150
Hospital (facility) copayment	$3,000
Other coinsurance	50%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$3,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,760**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$150
Hospital (facility) copayment	$3,000
Other coinsurance	50%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$150
Hospital (facility) copayment	$3,000
Other coinsurance	50%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,800
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Rocky Mountain Health Maintenance Organization, Inc., A UnitedHealthcare Company
NAME OF PLAN	Rocky Mountain Sky
1. Type of Policy	Individual Policy
2. Type of plan	Health Maintenance Organization (HMO)
3. Areas of Colorado where plan is available.	Plan is available only in the following areas: Eagle (80423, 80426, 80463, 81620, 81631, 81632, 81637, 81645, 81649, 81655, 81657, 81658), Grand, Lake and Summit Counties.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met. FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by 2 or more individuals.
5. Out-of-Pocket Maximum	INDIVIDUAL - The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met. FAMILY- the maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.
6. What is included in the In-Network Out-of-Pocket Maximum?	All deductibles, co-payments, and co-insurance, including those for prescription drugs.
7. Is pediatric dental covered by this plan?	Yes, pediatric dental is covered at 100% of allowable charges, subject to service limitations.
8. What cancer screenings are covered?	Subject to the parameters set forth below, cancer screening tests for the following items are covered subject to any applicable plan deductibles, co-payments/co-insurance, and maximum benefit levels: • Breast - Mammogram • Cervical - PAP test • Colorectal - Colonoscopy, Sigmoidoscopy, Fecal Occult Blood • Lung - Low dose CT • Ovarian - CA125 • Prostate - PSA Coverage for these cancer screening tests are subject to the following parameters: a) the test must be ordered by your physician, and b) you must comply with plan procedures

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes
10. Does the plan have a binding arbitration clause?	Yes	

Questions: Call 1-888-809-6539 or visit us at www.uhc.com.

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-809-6539. Si usted lo solicita, hay disponible una versión de este aviso completamente traducida en español.

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
Consumer Services, Life and Health Section
1560 Broadway, Suite 850, Denver CO 80202
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
Email: dora_insurance@state.co.us

Notice of Nondiscrimination

Rocky Mountain Health Plans (RMHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. RMHP does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

RMHP takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge:

- Provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters (remote interpreting service or on-site appearance)
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as:
  - Qualified interpreters (remote or on-site)
  - Information written in other languages

If you believe that RMHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance P.O. Box 30608
Salt Lake City, UTAH 84130
Email: UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call the toll-free number on your health plan ID card (TTY/RTT 711). We are available Monday through Friday, 8 a.m. to 8 p.m., ET.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1**-800-368-1019**, **1-800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building
Washington, D.C. 20201

Multi-Language Insert

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en la portada de esta guía.

請注意：如果您說中文(Chinese)，我們免費為您提供語言協助服務。請撥打本手冊封面所列的免付 費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Xin vui lòng gọi số điện thoại miễn phí dành cho hội viên trên trang bìa của tập sách này.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 이 책자 앞 페이지에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ngtulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nakalista sa harapan ng booklet na ito.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному на лицевой стороне данной брошюры.

المجاني على غلاف هذا الدليل. تنبيه: إذا كنت تتحدث العربية ، فهناك خدمات مساعدة لغوية مجانية متاحة. اتصل بالرقم

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo telefòn gratis pou manm yo ki sou kouvèti ti liv sa a.

ATTENTION : Si vous parlez français (French), des services d’aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone sans frais pour les affiliés figurant au début de ce guide.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny członkowski numer telefonu podany na okładce tej broszury.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número do membro encontrado na frente deste folheto.

ATTENZIONE: in caso la lingua parlata sia l’italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero verde per i membri indicato all'inizio di questo libretto.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer für Mitglieder auf der Vorderseite dieser Broschüre an.